U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 25 February 2003

In the Matter of

Robert G. Hitt,
Claimant

v.

Sewell Coal Company,
Employer

and

Director, Office of Workers' Compensation Programs,
Party-In-Interest

Case No. 2002-BLA-291

Appearances:

Debra Bailey, Mr. Hitt's Daughter
ForClaimant

Natalie D. Brown, Esq.
For the Employer

Before: Linda S. Chapman
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 *et seq*. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally

disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was held before the undersigned on October 11, 2002 in Raleigh, North Carolina, at which all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations, Parts 410, 718, 725, and 727. The Claimant's brief was filed on February 10, 2003; the Employer's brief was filed on February 11, 2003.

I have based my analysis on the entire record, including the transcript, exhibits, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

JURISDICTION AND PROCEDURAL HISTORY

The Claimant filed an application for black lung benefits on March 9, 1987, which was denied by the Director on September 1, 1987. The Claimant did not file an appeal, and his claim was administratively closed (DX 70-19).

On February 1, 1999, the Claimant filed a second application for black lung benefits, which was denied by the District Director on April 15, 1999 (DX 1, 16). The Claimant appealed the denial, and on February 11, 2000, the Director issued a Proposed Decision and Order of Reconsideration, denying the claim (DX 42). On March 9, 2000, the Director issued an Addendum to Proposed Decision and Order of Reconsideration, finding that additional information submitted by the Claimant did not alter the earlier determination of denial. The Director indicated that the file would be transferred to the Office of Administrative Law Judges for a formal hearing (DX 44).

On April 19, 2001, Administrative Law Judge Pamela L. Woods issued an Order Canceling Hearing and Staying Proceedings, after finding that it was not clear that the new regulations would not affect the outcome of the case. Judge Wood also indicated that, once the stay was lifted, it would be appropriate to remand the case so that a search could be made for the prior claim file (DX 61). On August 6, 2001, Judge Wood issued an Order of Remand, directing that the file be returned to the Director for reconstruction of the file (DX 66).

On December 17, 2001, the Director notified the Claimant that additional information submitted by the Claimant had been received, but that the Claimant was found not to be entitled to benefits (DX 68). On January 10, 2002, the Claimant requested a hearing before the Office of Administrative Law Judges (DX 69).[1]

[1] As the Claimant's claim was filed on February 1, 1999, the new regulations do not apply.

ISSUES PRESENTED [2]

The issues contested by the Employer and the Director are:

1. Whether the Claimant's claim was timely filed.
2. The length of the Claimant's coal mine employment.[3]
3. Whether the Claimant has pneumoconiosis.
4. Whether the Claimant's pneumoconiosis arose out of coal mine employment
5. Whether the Claimant is totally disabled.
6. Whether the Claimant's total disability is due to pneumoconiosis.

(DX 72; Tr. 12-14).

APPLICABLE STANDARD

The Claimant's February 1, 1999 claim was filed more than one year after his earlier claim was finally denied on September 1, 1987, by the Director, on the basis that the Claimant failed to establish that he had pneumoconiosis due to his coal mine employment, or that he was totally disabled by pneumoconiosis. His claim is considered a duplicate claim and must be denied pursuant to 20 C.F.R. 725.309 unless the Claimant can show that there has been a material change in conditions since the date of denial of the prior claim as a prerequisite to establishing his entitlement to benefits. In *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996)(*en banc)*, the Court adopted the "material change" standard established by the Sixth Circuit in *Sharondale Corp. v. Ross*,42 F.3d 993 (6th Cir. 1994), set forth as follows:

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

Id. at 997-998.

---

[2] "Tr." refers to the transcript of the hearing on July 13, 1999; "DX" refers to the Director's Exhibits; "EX" refers to the exhibits submitted by the employer in connection with the hearing; and "CX" refers to the exhibits submitted by the Claimant in connection with the hearing.

[3] The Director determined that the evidence verified 22 years and 3 months of coal mine employment. At the hearing, the Employer agreed to 22 years of coal mine employment, subject to the Claimant's testimony.

In applying the provisions of 725.309(d) and in attempting to determine whether a material change in conditions has occurred, only evidence relating to issues capable of change such as the existence of pneumoconiosis or total disability are relevant. In applying the duplicate claim standard in the Fourth Circuit, it is necessary to evaluate only the new evidence offered to determine if the claimant has satisfied at least one element, previously adjudicated against him, required to establish entitlement. As the previous claim was denied on the basis that the Claimant failed to establish that he had pneumoconiosis, or that he was totally disabled due to pneumoconiosis, I will initially determine whether the evidence submitted since the prior denial now establishes either of these elements of entitlement. If it does, the Claimant has established a material change in conditions, and his claim must be evaluated under Part 718, as amended. *See, Dotson v. Director, OWCP,* 14 B.L.R. 1-10 (1990). If it does not, then his duplicate claim must be denied.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made.

Background

The Claimant was born on January 3, 1941. He married his wife, Rose Marie Bryant, on April 24, 1959 (DX 1). I find that the Claimant has one dependent for purposes of augmentation.

Responsible Operator

The Employer does not contest its status as the responsible operator. This is consistent with the Claimant's Social Security earnings records, which reflect that Sewell Coal Company was the last coal mine employer for whom the Claimant was employed for at least one year, ending in 1988 (DX 6). Thus, I find that Sewell Coal Company is properly named as the responsible operator.

Length of Coal Mine Employment

The parties have also agreed that the Claimant has at least twenty two years of coal mine employment. Again, this is consistent with the Claimant's Social Security earnings records (DX 6). Thus, I find that the Claimant has at least twenty two years of coal mine employment.

Timeliness of the Claim

The Employer contests the timeliness of the Claimant's claim. The Claimant's original claim was filed on September 1, 1987. Twenty C.F.R. § 725.308 provides that

A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within

three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later.

The regulations also provide that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). The Board has held that a determination of total disability due to pneumoconiosis must be "actually received" by the miner, and if so, there must be a finding that the miner was capable of understanding the report. *Adkins v. Donaldson Mine Co.*, 19 B.R.R 1-34 (1993).

There is nothing in the exhibit record to indicate that the Claimant was diagnosed with a total disability due to pneumoconiosis at any time before he filed his application on September 1, 1987. Given the presumption that a claim is timely filed, and the total lack of any evidence to rebut this presumption, I find that the Claimant's claim for benefits was timely filed.

The New Medical Evidence

X-Ray Evidence[4]

The following new x-ray evidence is in the record.[5]

Exhibit No.	***Date of X-Ray***	***Reading Date***	***Physician/ Qualifications***	***Impression***
DX 67	11-18-87	6-11-99	Patel/B, BCR	1/0, s, s
DX 36	11-18-87	12-27-99	Goldstein/B	Negative

[4] B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[5] Although numerous readings were submitted as part of the duplicate claim, many of the x-rays on which they are based predate the September 1987 final denial by the Director. In determining whether the Claimant has established a material change of conditions since that time, I have considered only the readings of x-rays that were performed after the September 1987 denial.

DX 34	11-18-87	12-13-99	Sargent/B, BCR	Negative for pneumoconiosis
DX 67	3-5-99	6-11-99	Patel/B, BCR	1/0, s, t
DX 53	3-5-99	10-9-00	Castle/B	Negative for pneumoconiosis
DX 32	3-5-99	3-5-99	Hayes	Negative
DX 27	3-5-99	8-20-99	Shipley/B, BCR	Negative for pneumoconiosis
DX 25	3-5-99	8-15-99	Spitz/B, BCR	Negative
DX 23	3-5-99	8-6-99	Wiot/B, BCR	Negative for pneumoconiosis
DX 18	3-5-99	4-12-99	Sargent/B, BCR	Negative for pneumoconiosis
DX 67	6-10-99	6-11-99	Patel/B, BCR	1/0, s, s
DX 38	6-10-99	12-2-99	Shipley/B	Negative
DX 32	6-10-99	10-10-99	Spitz/B, BCR	Negative
DX 30	6-10-99	9-20-99	Wiot/B, BCR	Negative
DX 70	11-23-99	11-23-99	Johnson	Interval development of linear densities in left mid and lower lung fields consistent with atelectasis; similar, less focal changes in right lung base
DX 54	11-02-00	11-02-00	Jarboe/B	Negative
EX 20	5-3-02	5-7-02	Lorentzen	Scattered calcified granulomata; questionable nodular density in lateral left lung
EX 25	5-3-02	9-18-02	Wheeler/B, BCR	Negative for pneumoconiosis
EX 25	5-3-02	9-18-02	Scott/B, BCR	Negative for pneumoconiosis
CX G	5-3-02	7-26-02	Patel/B, BCR	1/0, t, t
EX 20	5-17-02	5-17-02	D'Angelo	No persistent nodule in left lung; lungs appear clear
EX 25	5-17-02	9-18-02	Wheeler/B, BCR	Negative for pneumoconiosis

EX 25	5-17-02	9-18-02	Scott/B, BCR	Negative for pneumoconiosis
CX H	5-17-02	7-26-02	Patel/B, BCR	1/0, t, t

The following new pulmonary function study evidence is in the record.

Pulmonary Function Studies

Exhibit No.	***Date***	***Age/Ht***	***FEV1***	***FVC***	***MVV***	***Effort***	***Qualifying/Valid***
DX 10	3-5-99	58/69	2.52	3.11	67	Good	No/Yes
EX 11	10-20-99	58/67	3.49 3.44*	4.24 4.13*	127 134*		No/Yes
DX 65	9-27-00	59/67	1.53 1.53*	2.93 3.20*		Subma ximal	Yes/No

* Results after administration of bronchodilator

Dr. Fino, who reviewed the pulmonary function study evidence, determined that the MVV values obtained in the March 5, 1999 study were invalid, although he did not explain why. Dr. Repsher felt that these tests were not medically interpretable, due to poor effort and cooperation on the part of the Claimant. However, as pointed out by the Claimant, the technician who actually performed the study noted that the Claimant's effort and cooperation were good, and Dr. Durr, who reviewed the results, found the data to be acceptable and reproducible. Therefore, I find that the March 5, 1999 spirometry tests produced valid and reliable results.

Dr. Rasmussen ordered and reviewed the October 20, 1999 results, and the record includes the tracings. In the absence of any contrary evidence, I find these results to be valid and reliable.

Dr. Fino concluded that the results of the September 27, 2000 study were invalid, due to premature termination to exhalation, lack of reproducibility in the expiratory tracings, and lack of abrupt onset to exhalation. Dr. Repsher also concluded that these studies were invalid, due to extremely poor effort and cooperation, as documented by the technician. Indeed, the technician commented: "Unable to obtain maximal efforts during tests or reproducible date therefore ATS standards criteria not met. Variability in vital capacities and post bronchodilator results not reliable" (DX 65). Finally, Dr. Ghio, at whose request the studies were performed, concluded that the spirometry was not reproducible. I conclude that the October 20, 1999 study is invalid, and therefore the results are not reliable.

The following new arterial blood study evidence is in the record.

Arterial Blood Gas Studies

Exhibit No.	***Date***	***Physician***	***pCO2***	***pO2***	***At rest/ exercise***	***Qualifying***
DX 12	3-5-99	Hayes	38/36	81/84	At rest/After exercise	No
EX 11	10-20-99	Rasmussen	36/34	83/86	At rest/After exercise	No

Medical Opinion Evidence

The following new medical opinion evidence is in the record.

Dr. James R. Castle

Dr. Castle reviewed the Claimant's medical records at the request of the Employer, and prepared a report dated September 17, 1999 (DX 27). Based on this review, he concluded that the Claimant does not suffer from pneumoconiosis. He noted that the Claimant worked in the coal mines for a sufficient time to have developed pneumoconiosis if he were a susceptible host. His past smoking history was also a risk factor for the development of pulmonary disease.

However, at no time did the Claimant have any physical findings indicating the presence of an interstitial pulmonary process as expected with pneumoconiosis, such as persistent findings of rales, crackles, or crepitations. In fact, his chest examination was essentially normal. The majority of the B readers who reviewed x-rays concluded that there was no evidence of pneumoconiosis. Dr. Patel found a degree of minimal simple pneumoconiosis, but indicated that the opacities were irregular, which is not typical for coal workers' pneumoconiosis. Rather, this type of opacity is seen with a heavy tobacco smoking history, recurrent bronchitis, obesity, and other forms of pneumoconiosis. In Dr. Castle's opinion, the x-rays did not show evidence of pneumoconiosis.

Dr. Castle noted that the valid physiologic studies showed no obstruction, and a very mild degree of restriction, probably related to the Claimant's obesity. Resting and exercise blood gas study results were also normal.

Thus, Dr. Castle stated that the Claimant did not have the physical, radiographic, physiologic, or arterial blood gas findings to indicate the presence of pneumoconiosis. He felt

that the Claimant was not permanently and totally disabled, such that he would not be able to perform his regular coal mining work or work requiring similar effort. In his opinion, the Claimant does not suffer from a chronic dust disease, or the sequelae thereof, caused by, contributed to, or substantially aggravated by his exposure to coal mine dust. Nor does he have any impairment or disability caused by coal mine dust exposure or coal workers' pneumoconiosis.

Dr. Castle reviewed additional records and prepared a report dated May 22, 2001 (DX 63). He again concluded that the Claimant does not suffer from pneumoconiosis. Dr. Castle noted that the Claimant worked in or around coal mines for a sufficient time period to develop pneumoconiosis if he were a susceptible host. He also noted the Claimant's additional risk factor for the development of pulmonary disease, i.e., his fifteen pack years of smoking. In addition, Dr. Castle stated that the Claimant's obesity was another risk factor for the development of pulmonary symptoms.

However, based on his review of the medical records, Dr. Castle did not note any consistent findings suggesting an interstitial pulmonary process, such as rales, crackles, or crepitations. In fact, his pulmonary examinations have been essentially normal.

Dr. Castle noted that the vast majority of B readers and radiologists concluded that there was no evidence whatsoever of any form of pneumoconiosis. Although Dr. Patel felt that there was evidence of pneumoconiosis, he indicated that the opacities were irregular, and not typical of opacities of pneumoconiosis, which are rounded.

According to Dr. Castle, the pulmonary function study performed by Dr. Hayes showed a very mild degree of restriction, but no evidence of obstruction. The tests performed by Dr. Ghio were invalid, but still showed normal total lung capacity and forced vital capacity. Thus, there was no evidence of any significant respiratory impairment demonstrated by valid pulmonary function studies.

The arterial blood gas study performed by Dr. Hayes produced normal results both at rest, and after exercise. The Claimant's oxygen saturation and blood gas transfer mechanisms were also normal.

Thus, Dr. Castle concluded that the Claimant does not have the physical, radiographic, physiologic, or arterial blood gas findings to indicate the presence of pneumoconiosis. Dr. Castle also concluded that the Claimant is not permanently and totally disabled due to any pulmonary process, including pneumoconiosis. He felt that the Claimant retained the respiratory capacity to perform his usual coal mining employment or similar work.

Dr. Castle reviewed additional medical records, and prepared a report dated September 12, 2002 (EX 17). He continued to believe that the Claimant does not suffer from coal workers' pneumoconiosis. He noted that Dr. Rasmussen's physical examination of October 20, 1999 was unremarkable, and the valid pulmonary function studies were totally normal, showing no

respiratory impairment from any cause. Dr. Rasmussen's arterial blood gas studies were also totally normal, with a normal response to exercise. Noting that Dr. Patel interpreted the x-ray as showing s/s type opacities with a profusion of 1/1, he stated that these irregular, linear opacities were not typical of the opacities seen in coal workers' pneumoconiosis. In addition, numerous other B readers and radiologists have found no evidence whatsoever of radiographic changes consistent with pneumoconiosis.

Dr. Castle concluded that the Claimant does not suffer from pneumoconiosis, and has no respiratory impairment from any cause. He retains the respiratory capacity to perform any and all coal mining duties.

Dr. Gregory L. Fino

Dr. Fino reviewed the Claimant's medical records at the request of the Employer, and prepared a report dated September 18, 1999 (DX 27). He noted that the Claimant's March 1999 pulmonary function study showed a slight decrease in the FVC and FEV1, but the MVV was invalid. The TLC and diffusing capacity were normal. The arterial blood gas studies were normal, with no pulmonary limitation to exercise.

Dr. Fino concluded that the Claimant does not suffer from an occupationally acquired pulmonary condition as a result of his coal mine dust exposure. He based this conclusion on the fact that the majority of the chest x-ray readings were negative for pneumoconiosis. Additionally, the acceptable spirometric evaluation was normal, with no obstruction, restriction, or ventilatory impairment. He felt that the decrease in the FVC was not due to pulmonary fibrosis, but was due to obesity. Finally, the diffusing capacity values were normal, ruling out the presence of clinically significant pulmonary fibrosis, of which pneumoconiosis is an example.

Dr. Fino felt that from a functional standpoint, the Claimant's pulmonary system was normal, and he retained the physiologic capacity from a respiratory standpoint to perform all of the requirements of his last job. In sum, there was insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis. In his opinion, the Claimant does not suffer from an occupationally acquired pulmonary condition. He has a mild respiratory impairment due to obesity, but is neither partially nor totally disabled from returning to his last coal mining job or a job requiring similar effort.

Dr. Fino reviewed additional medical records, and prepared a report dated May 23, 2001 (DX 63). He noted the Claimant's history of 24 years of coal mine employment, as well as his past smoking history. According to Dr. Fino, the pulmonary function study of September 27, 2000 was invalid due to premature termination to exhalation, lack of reproducibility in the expiratory tracings, and lack of an abrupt onset to exhalation. Thus, the values obtained represent at least the Claimant's minimal lung function, but not his maximum lung function.

Dr. Fino concluded that the Claimant does not suffer from an occupationally acquired

pulmonary condition as a result of coal mine dust exposure. He based his conclusion on the fact that the majority of chest x-ray readings were negative. Additionally, although there were no new acceptable spirometric evaluations, the March 1999 study was essentially normal, and showed no impairment in ventilation. The diffusing capacity values were normal, ruling out the presence of clinically significant pulmonary fibrosis. According to Dr. Fino, from a functional standpoint, the Claimant's pulmonary system is normal, and he retains the physiologic capacity from a respiratory standpoint to perform all of the requirements of his last job, which Dr. Fino assumed required sustained heavy labor.

Dr. Fino reviewed additional medical records and prepared a report dated September 20, 2002 (EX 27). He noted that Dr. Zavelo referred to a pulmonary function study done on May 3, 2002, but that no tracings had been provided. Thus, the study was nonconforming, and the best that could be said about it was that it showed the Claimant's minimal lung function. But it could not be used as medical evidence of respiratory impairment, as it is impossible to determine if it represented the Claimant's true and maximal lung function.

Dr. Fino stated that his review of the additional medical information did not cause him to change any of his earlier opinions.

Dr. Lawrence H. Repsher

Dr. Repsher reviewed the results of the September 27, 2000 pulmonary function study, and prepared a report dated April 26, 2001 (DX 62). Dr. Repsher is board certified in internal medicine and pulmonary medicine, ans is a B reader. He stated that the test was uninterpretable for the presence of pulmonary disease, due to the extremely poor effort and cooperation of the Claimant, as documented by the technician. According to Dr. Repsher, "however, this test does include parameters which are relatively effort independent, all of which are well within normal limits."

Dr. Repsher concluded that there is no evidence of pneumoconiosis, or of any respiratory or pulmonary disease or condition of any kind. In his opinion, the Claimant does not and has never suffered from pneumoconiosis, or any other respiratory or pulmonary disease or condition either caused by or aggravated by his employment with the Employer.

Dr. Repsher reviewed medical records at the request of the Employer, and prepared a report dated March 13, 2001 (DX 62). He noted that the Claimant worked as a coal miner for 22-23 years, and that he had been awarded black lung benefits by the State of West Virginia in 1984. He also noted the Claimant's past smoking history.

Dr. Repsher concluded that the Claimant did not and had not ever suffered from pneumoconiosis or any other respiratory or pulmonary disease or condition either caused by or aggravated by his work for the Employer. He based this conclusion on the fact that there was no x-ray, pulmonary function, or arterial blood gas evidence of pneumoconiosis. He felt that the

Claimant's symptoms of dyspnea on exertion could be explained by his obesity and poor condition, and he recommended evaluation by an internist or cardiologist to rule out heart disease.

In Dr. Repsher's opinion, there was insufficient objective evidence to justify a diagnosis of pneumoconiosis. Nor did the Claimant have any pulmonary or respiratory impairment. He felt that the Claimant's apparent restrictive disease was overwhelmingly likely due to his poor effort and cooperation with testing. In his opinion, the Claimant's degree of obesity would not be sufficient to cause significant restrictive impairment. Dr. Repsher stated that the Claimant was clearly capable of continuing his regular coal mining work from a respiratory standpoint, especially in vies of his normal arterial blood gas study results at rest and after exercise.

Dr. Repsher testified by deposition on May 11, 2001 (DX 64). He noted that interpretation of the Claimant's pulmonary function testing was complicated by the fact that he never fully cooperated. However, the effort independent testing done in September 2000 produced normal results, including normal diffusing capacity, ruling out any clinically significant cigarette smoking induced lung disease, as well as any clinically significant coal dust lung disease. Interstitial diseases such as pneumoconiosis cause significant reduction in diffusing capacity.

In Dr. Repsher's opinion, the Claimant does not have coal workers' pneumoconiosis, although he noted that it was possible that he could have histologic evidence of pneumoconiosis that would show up under a microscope. He felt that the Claimant had sufficient functional respiratory capacity to perform his former coal mine work, based on his pulmonary function test results, which were probably normal. According to Dr. Repsher, the Claimant does not have any respiratory impairment caused by, related to, or aggravated by his exposure to coal mine dust. He has no x-ray , pulmonary function test, or arterial blood gas evidence of pneumoconiosis, nor is there any histology to determine if he has microscopic evidence of pneumoconiosis.

Dr. Repsher reviewed additional medical records, and prepared a report dated September 4, 2002 (EX 13). It remained his opinion that there is insufficient objective information to justify a diagnosis of coal workers' pneumoconiosis. In his view, the Claimant does not have any pulmonary or respiratory impairment, and is clearly capable of continuing his regular coal mining work from a respiratory standpoint.

Andrew J. Ghio

Dr. Ghio, who is board certified in pulmonary and internal medicine, and is a B reader, performed a pulmonary evaluation at the request of the Employer, and prepared a report dated October 16, 2000 (DX 62). He noted the Claimant's history of coal mine employment, as well as his smoking history. His examination of the Claimant's lungs was normal, with no crackles or wheezes. He was not able to interpret the results of the Claimant's pulmonary function study, as the spirometry was not reproducible. He noted that the lung volumes revealed a mild restriction, and the diffusing capacity and oxygen saturation were normal. He interpreted the Claimant's x-ray as normal, as did the radiologist. He indicated that the other chest x-rays provided by the

Claimant were also interpreted as normal. Based on this information, Dr. Ghio concluded that there was no support for a diagnosis of pneumoconiosis.

Dr. Ghio testified by deposition on February 9, 2001 (DX 62). He discussed his examination of the Claimant, and his report of October 16, 2000. Again, he noted the Claimant's 24 year history of coal dust exposure. On examination of the Claimant, he found no respiratory system abnormalities. He stated that the Claimant's spirometry results were unreliable, because they were not reproducible. The Claimant's total lung capacity was slightly diminished; his oxygen saturation was normal. Dr. Ghio reviewed the Claimant's x-ray, which he found to be completely normal. He also looked at eight to ten x-rays that the Claimant had with him, which he also felt were normal. He found no evidence of respiratory disease or impairment attributable to the Claimant's exposure to coal mine dust; indeed, he found no evidence of impairment.

Dr. Ghio prepared an additional report dated August 26, 2002 (DX 12). He noted that all examinations had been normal but for evidence of obesity, decreased breath sounds, and a diastolic murmur. The first set of pulmonary function test results, on March 5, 1999, showed a mild restrictive defect. On October 29, 1999, the pulmonary function test results were normal, as was exercise testing. Test results from September 27, 2000 yielded invalid results, due to a lack of cooperation by the Claimant. Even so, the results reflected normal function. The arterial blood gas studies of March 5, 1999 and October 20, 1999 yielded normal results.

Dr. Ghio noted that one individual had made positive B readings of the Claimant's chest x-rays. However, many more B readers interpreted these films as negative, showing no evidence of pneumoconiosis.

Dr. Ghio acknowledged that the Claimant has respiratory symptoms, including shortness of breath after walking, cough, phlegm, wheeze, and chest pain. However, his physical examination was always normal, except for obesity and diminished breath sounds. Such symptoms are nonspecific, and could possibly reflect injury after either coal dust exposure or smoking. However, shortness of breath, cough, phlegm, and wheezing are more strongly associated with smoking than with pneumoconiosis. Also, diminished breath sounds are frequently observed with smoking, but rarely with pneumoconiosis. Dr. Ghio felt that the results of the Claimant's pulmonary functions tests, including spirometry, lung volumes, and diffusing capacity, did not support a finding of significant damage associated with either cigarette smoking or coal dust exposure, as they most recently were normal. His exercise testing was also normal, as were all arterial blood gases.

Dr. Ghio felt that the x-ray evidence did not support a diagnosis of pneumoconiosis, as only one B reader interpreted any x-ray as positive, whereas at least eight B readers felt that the x-rays were normal. He noted that many of these physicians are leaders in the field of B reading.

Dr. Ghio felt that a diagnosis of pneumoconiosis was not warranted, and that the Claimant's symptoms and changes on examination should be viewed as associated with his

cigarette smoking. He stated that, using the American Medical Association and American Thoracic Society criteria, the Claimant has no respiratory impairment, and he should be able to perform his regular coal mining work or work requiring similar effort.

Dr. Ghio testified by deposition on August 29, 2002 EX 16). He reiterated that the Claimant's pulmonary function tests showed normal pulmonary function, as did his arterial blood gas studies. Thus, physiologically, the Claimant has normal lung function. In his opinion, the Claimant has absolutely no impairment under the American Medical Association or American Thoracic Society's criteria.

Dr. Ghio discussed Dr. Proctor's June 14, 199 report, indicating that before he stopped, the Claimant smoked enough cigarettes to cause some amount of lung injury. Thus, despite decades of abstinence, he will continue to demonstrate that injury clinically with shortness of breath with exertion, cough, and phlegm production. He noted that the Claimant's primary physician had recognized this, and was treating him with inhalers. Thus, his inability to tolerate dusty environments likely reflects his years of cigarette smoking and lung injury therefrom. He noted that Dr. Proctor referred to no objective measure to substantiate her claim that the Claimant was impaired.

Dr. Ghio reviewed additional medical records and prepared a report dated September 14, 2002 (EX 21). He noted that the Claimant's complaints of shortness of breath after walking, cough, phlegm, and wheeze are more strongly associated with smoking than with pneumoconiosis, and in fact the Claimant was currently being treated for chronic obstructive pulmonary disease associated with cigarette smoking.

Dr. Ghio felt that the results of the Claimant's pulmonary function tests did not support the conclusion that there was significant damage associated with either smoking or coal dust exposure, as they were normal. He noted that results obtained by Dr. Zavelo on May 3, 2002 were provided without tracings, and should be disregarded. Nor did the most recent x-ray interpretations change his conclusion that the Claimant does not have pneumoconiosis. He noted that Dr. Patel had read six of the Claimant's films as showing pneumoconiosis 1/0, but at least eight B readers felt these x-rays were normal. Given that many of these physicians are leaders in the field of B reading, he gave their opinions more weight.

Dr. Ghio stated that the development of abnormal pulmonary function results and abnormal opacities on x-ray could be associated with coal dust exposure only with great difficulty. He noted that the Claimant's last exposure to coal dust was about 14 years earlier. While dust-associated diseases can progress, such progression is almost always in individuals with higher profusions, and the Claimant is not one of them.

Dr. D. Allen Hayes

Dr. Hayes examined the Claimant at the request of the Department of Labor, and testified

by deposition on September 29, 1999 (DX 11, 32). He is board certified in internal and pulmonary medicine, and is a B reader. His physical examination of the Claimant was normal, with no abnormal breath sounds, no wheeze, no evidence of any asymmetry of respiration, and no dullness to percussion. The Claimant was about 50 pounds overweight. The Claimant's pulmonary function study showed a mild restrictive impairment; his arterial blood gas study results were normal, both at rest and after exercise. Dr. Hayes reviewed the Claimant's x-ray, and found that it did not show any evidence suggestive of pneumoconiosis.

Dr. Hayes diagnosed the Claimant with a mild restrictive pulmonary impairment, most likely due to his obesity, and based on his history of chronic cough producing sputum, felt that he had evidence of chronic bronchitis, most likely due to his past smoking history. In Dr. Hayes' opinion, none of the Claimant's mild respiratory impairment was due to his exposure to coal mine dust.

Dr. Camilla A. Proctor

Dr. Proctor submitted a letter dated June 14, 1999, indicating that the Claimant had been under her care since April 7, 1999 due to breathing difficulty. Dr. Proctor is board certified in internal medicine; she specializes in internal medicine and pulmonary disease; she is not a B reader. She noted that on examination, he had decreased breath sounds. She noted that when she first saw the Claimant, he was one week away from his last dusty employment; the Claimant tried to return to work in a dusty job, but resigned because he was short of breath on exposure to dust. She noted that the Claimant's history was consistent for unacceptable dyspnea with dust exposure; his pulmonary function testing showed only mild pulmonary restriction.

Dr. Proctor noted the Claimant's history of coal mine employment, as well as his estimated fifteen pack year history of cigarette smoking. According to Dr. Proctor, since 1982 the Claimant has had reoccurring episodes of wheezing, dyspnea, and productive cough. She indicated that his most recent x-ray of June 10, 1999 showed opacities classifiable as simple pneumoconiosis by Dr. Patel, who also read the March 5, 1999 x-rays with the same conclusion.

Based on the Claimant's twenty four years of abstinence from cigarette smoking, Dr. Proctor could see no other logical etiology for the Claimant's inability to tolerate a dusty environment such as a coal mine, other than coal dust exposure. She stated:

> Thus it is inevitable to say that he is totally unable to preform [sic] coal mine work as either a "coarse coal operator" or as a mechanic or any similar coal dust exposure job. His symptoms almost certainly relate to his former coal mining employment.

Dr. Proctor testified by deposition on August 28, 2002 (EX 15). She testified that she treated the Claimant from April 1999 to June 2000. According to Dr. Proctor, the Claimant had arterial blood gas studies on August 30, 1999, which showed "reasonably normal" results. She stated that the results did not indicate that the Claimant was disabled from a respiratory

standpoint.

Dr. Proctor stated that her opinion, that the Claimant was unable to perform coal mine work or any job with similar dust exposure, was based on the Claimant's history, and his admission to the hospital in November 1999 with acute epiglottitis, a terrible swollen sore throat caused by infection.

Dr. Proctor acknowledged that the pulmonary function results obtained by Dr. Rasmussen on October 20, 1999 were normal, and would not support a finding of total disability. She stated that during her treatment of the Claimant, she did not obtain any test results that objectively supported a finding of total respiratory disability. She thought that she may have seen one of the Claimant's x-rays, according to her June 1, 1999 treatment notes, and she agreed with the observation of plate-like atelectasis. She stated that one of the causes of plate-like atelectasis is pneumoconiosis.

Dr. D.L. Rasmussen

Dr. Rasmussen examined the Claimant on October 20, 1999 (EX 11). He noted the Claimant's history of coal mine employment, as well as his history of cigarette smoking. On examination of the Claimant, Dr. Rasmussen found his chest expansion and diaphragmatic excursions to be normal. His breath sounds were normal, with no rales, rhonchi, or wheezes. The Claimant's June 10, 1999 x-ray was interpreted by Dr. Patel as showing pneumoconiosis with a profusion of 1/1, s, s, throughout all lung zones. Dr. Patel also reviewed a March 5, 1999 x-ray, finding pneumoconiosis with a profusion of 1/0, s, t, in all lung zones. Finally, Dr. Patel found pneumoconiosis with a profusion of 1/0, s, s, in all lung zones, on a November 18, 1987 film.

The Claimant's ventilatory function studies were normal, without significant change after bronchodilator therapy. The minimum breathing capacity and single breath carbon monoxide diffusing capacity were normal, as were blood gases at rest. The exercise studies showed no measurable loss of respiratory function. Dr. Rasmussen concluded that the Claimant retained the pulmonary capacity to perform his last regular coal mine job.

Dr. Rasmussen stated that the Claimant had a significant exposure to coal mine dust and x-ray changes consistent with pneumoconiosis, and thus it was medically reasonable to conclude that he has coal workers' pneumoconiosis that arose from his coal mine employment. However, that exposure has not produced significant loss of pulmonary function.

Dr. Thomas M. Jarboe

Dr. Jarboe reviewed the Claimant's medical records at the request of the Employer, and prepared a report dated September 4, 2002 (EX 14). Based on his review, he concluded that there was not sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. In Dr. Jarboe's opinion, there was not sufficient x-ray evidence of pneumoconiosis. He noted that

he reviewed one of the Claimant's x-rays, and found no evidence of pneumoconiosis; several other highly qualified B readers who reviewed multiple x-rays found them negative for pneumoconiosis.

Nor did Dr. Jarboe feel that the pulmonary function study results supported such a diagnosis. He noted that Dr. Hayes found a mild restrictive defect on the March 5, 1999 study, but that subsequent pulmonary function studies performed with a body box showed a total lung capacity of 87%, which is completely normal. In other words, no restrictive defect could be demonstrated with an extremely accurate method of measuring lung volumes. He noted that the Claimant did not have any evidence of airflow obstruction. Thus, the Claimant has no restriction or obstruction to suggest the diagnosis of a dust induced lung disease.

According to Dr. Jarboe, the Claimant does not have any significant respiratory impairment. He noted that the Claimant had no obstruction or restriction; his diffusion capacity was normal; his oxygen tension was normal at rest and after exercise, indicating a completely normal gas exchange. Thus, Dr. Jarboe felt there was no evidence of any impairment.

Dr. Jarboe concluded that the Claimant could return to his regular coal mining work or work requiring similar effort. He found no evidence of a totally and permanently disabling respiratory condition caused by or substantially contributed to by the inhalation of coal mine dust or the presence of coal workers' pneumoconiosis.

Dr. Jarboe reviewed additional medical records, and prepared a report dated September 17, 2002 (EX 23). These additional records did not change his previous opinion, that there is not sufficient evidence for a diagnosis of coal workers' pneumoconiosis. He noted that Dr. Patel was the only B reader to read the x-rays as positive for pneumoconiosis, whereas numerous highly qualified B readers have read them as negative. Dr. Jarboe also reviewed the Claimant's most recent x-ray, finding it negative.

The additional medical records that Dr. Jarboe reviewed also provided physiological data that does not support a diagnosis of a dust induced lung disease. He noted the completely normal spirometry results obtained by Dr. Rasmussen, with no evidence of restrictive or obstructive lung disease, or any impairment of gas exchange. Dr. Zavelo referred to abnormal spirometry results, but did not provide tracings to validate his study.

Dr. Ben V. Branscomb

Dr. Branscomb reviewed the Claimant's medical records at the request of the Employer, and prepared a report dated September 9, 2002 (EX 18). He noted the Claimant's coal mine employment history and smoking history, indicating that the Claimant's abstinence from smoking did not negate the potential detrimental effects of his earlier exposure.

Dr. Branscomb concluded that there was no objective evidence to support a diagnosis of

coal workers' pneumoconiosis in the Claimant. Specifically, there was no indication of any pulmonary or respiratory impairment, or any objective indication of any respiratory disease of any etiology. He also noted that there was no consistent subjective history of any pulmonary disease. He stated that the objective data confirmed that the Claimant's pulmonary function is "entirely sufficient" for him to return to his previous coal mine or other similar work. He noted that the Claimant was substantially overweight, and had seen physicians for a few minor non-pulmonary conditions. However, from a pulmonary standpoint, he has no impairment whatsoever.

Dr. Branscomb reviewed additional medical records, and prepared a report dated September 16, 2002 (EX 24). He noted that none of the physicians who examined the Claimant or reviewed his records attributed any bronchitis, dysfunction, or pulmonary change either directly or indirectly to coal mine dust. Additionally, they all concluded that the Claimant had no disability that would interfere with his performance of his former coal mine or similar work. He felt that the additional materials he reviewed supported his previous opinion, that there is no objective evidence of any pulmonary disability of any etiology, nor is there any indication of any pneumoconiosis or any other disease or impairment caused or adversely influenced by coal mine dust exposure.

Dr. Jerome F. Wiot

Dr. Wiot testified by deposition on October 2, 2002 (EX 28). Dr. Wiot is board certified in radiology, and is emeritus professor of radiology at the University of Cincinnati. Dr. Wiot reviewed the Claimant's chest x-rays, including his most recent x-rays in May 2002. He assumed that the Claimant had a sufficient history of exposure to coal mine dust to cause lung disease in a susceptible individual. He concluded that the Claimant had a few small calcified granulomas, which was a normal finding, especially for a person in the Ohio valley area, where so many people have histoplasmosis. Other than that, he stated that the x-rays were fine, with no evidence of coal workers' pneumoconiosis, or anything else.

Dr. Wiot noted that the Claimant last worked as a coal miner in 1988, and statistics showed that if a miner leaves the coal mine with no evidence of pneumoconiosis, the chance of him developing pneumoconiosis is very limited; it if does happen, it is a very minimal change.

Dr. Craig M. Zavelo

Dr. Zavelo provided a letter dated August 12, 2002, indicating that he met the Claimant on July 3, 2002, with a chief complaint of "feeling sick" (CX K). He stated that the Claimant was having significant exacerbation of his chronic pulmonary disease, and had had recurrent exacerbations, including bronchitis, cough, congestion, wheezing, and shortness of breath.

Dr. Zavelo referred to spirometry testing performed on May 3, 2002, the results of which were compatible with moderate airway obstruction. He indicated that the Claimant was being treated with Combivent, Flovent, and Singulair. The Claimant's acute exacerbation had

improved, but his breathing tests had not normalized, and he continued to have consistent airway obstruction.

Dr. Zavelo noted that the Claimant worked in the coal mines for 23 years, and smoked a pack and a half of cigarettes a day for ten years, ending in 1974. Dr. Zavelo felt that the Claimant suffers with significant lung problems with airway obstruction, and that his chest x-ray shows granulomatous changes.

Dr. Zavelo wrote a letter on October 10, 2002, on behalf of the Claimant (CX P). He repeated his statements in his previous letter, noting additionally that after a bout of bronchitis, the Claimant's spirometry in August showed a worsening FEV1. He indicated that the Claimant was hospitalized for chest discomfort on October 9, 2002. Dr. Zavelo stated that given the Claimant's lung problems, he should not work in the coal mines.

Dr. Bennie L. Jarvis

Dr. Jarvis examined the Claimant on November 29, 1999 (CX O). He noted that the Claimant exhibited no obvious airway distress even when lying flat, and that his chest was clear. According to Dr. Jarvis, the Claimant's chest x-ray showed some changes consistent with chronic pulmonary disease. He diagnosed the Claimant with acute epiglottitis.

DISCUSSION

In his September 1, 1987 determination, the Director found that the Claimant had not established that he had pneumoconiosis, or that he was totally disabled due to pneumoconiosis. Thus, I must review the newly submitted evidence to determine whether the Claimant has established a change in condition with respect to either of these elements of entitlement.

Existence of Pneumoconiosis

Pneumoconiosis is defined, by regulation, as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. 718.201. The regulations at 20 C.F.R. 718.203(b) provide that, if it is determined that the miner suffered from pneumoconiosis and has engaged in coal mine employment for ten years or more, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. If, however, it is established that the miner suffered from pneumoconiosis but worked less than ten years in the coal mines, then the Claimant must establish causation by competent evidence. *Stark v. Director, OWCP*,9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*,9 B.L.R. 1-137 (1986). The Board has held that the burden of proof is met under 718.203(c) where "competent evidence establish(es) that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP,* 11 B.L.R. 1-1101-112 (1987). Specifically, the record must contain *medical* evidence to demonstrate causation. *Baumgartner v. Director, OWCP,* 9

B.L.R. 1-65, 1-66 (1986)(administrative law judge cannot infer causation based solely upon claimant's employment history); *Tucker v. Director, OWCP*, 10 B.L.R. 1-35, 1-39 (1987)(it was error for the administrative law judge to rely solely upon lay testimony to find causation established). The Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See, Director, OWCP v. Greenwich Collieries,* 114 S.Ct. 2251 (1995).

Because the current claim was filed after the enactment of the Part 718 regulations, the newly submitted evidence will be evaluated under standards found in 20 C.F.R. Part 718. The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. 718.202(a). I have independently assessed the newly submitted evidence under each of these methods.

.

To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

In this case, there is a conflict in opinion as to whether the Claimant suffers from coal workers' pneumoconiosis. Specifically, Dr. Patel has interpreted the Claimant's x-rays as showing pneumoconiosis, while all of the other physicians who have interpreted the x-rays have concluded that they do not show pneumoconiosis. In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretations, favorable and unfavorable, may be a factor. *Wilt v. Wolverine Mining Company*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *Akins v. Director, OWCP,* 958 F.2d 49 (4th Circuit 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 B.L.R. 1-344 (1985) and *Melink v. Consolidation Coal Company,* 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). In addition, the Board has held that the interpretation of an x-ray by a physician who is a board certified radiologist as well as a B reader may be given more weight than the interpretations of a physician who is only a B reader. *Scheckler v. Clinchfield Coal Co.,* 7 BLR 1-128 (1984). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations of one x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present. *Copley v. Arch of West Virginia, Inc.,* Case No. 93-1940 (4th Circuit June 21, 1994)(unpublished). Where there is a conflict among x-ray interpretations, it must be resolved by the administrative law judge as a trier of fact. *Dees v. Peabody Coal Co.,* 5 BLR 1-117 (1982); *Stritzel v. Zeigler Coal Co.,* 4 BLR 1-35 (1981); *Elkins v. Beth Elkorn Corp.,* 2 BLR 1-683

(1982).

The record includes 24 interpretations of seven x-rays that have been taken since the Claimant's claim was denied in September 1987. The first, on November 18, 1987, was interpreted as positive for pneumoconiosis by Dr. Patel, who is dually qualified. However, Dr. Sargent, who is also dually qualified, and Dr. Goldstein, who is a B reader, interpreted it as negative. I find that the interpretations of this x-ray are, at best, in equipoise, and thus it is not positive for the existence of pneumoconiosis.

The next x-ray, on March 5, 1999, was again interpreted by Dr. Patel as positive. However, six other readers (four dually qualified physicians, one B reader, and one physician whose qualifications are unknown) interpreted this same x-ray as negative. Given the preponderance of negative interpretations by the most highly qualified physicians, I find that this x-ray is negative for pneumoconiosis.

The next x-ray, dated June 10, 1999, was interpreted by Dr. Patel as positive. However, two dually qualified physicians and one B reader interpreted it as negative. Given the preponderance of negative interpretations by dually qualified physicians, I find that this x-ray is negative for pneumoconiosis.

The next x-ray was taken on November 2, 2000, and was interpreted by Dr. Jarboe, a B reader, as negative; there are no positive interpretations.

The next x-ray, taken on November 23, 1999, was read by Dr. Johnson, whose qualifications are unknown. Dr. Johnson made no findings consistent with pneumoconiosis. I find that this x-ray is negative for pneumoconiosis.

The next x-ray was taken on May 3, 2002, and was interpreted by Dr. Patel as positive for pneumoconiosis. However, Dr. Wheeler and Dr. Scott, both dually qualified physicians, interpreted it as negative. Dr. Lorentzen, whose qualifications are unknown, made no findings of pneumoconiosis. Again, given the preponderance of negative interpretations by the most highly qualified physicians, I find that this x-ray is negative for pneumoconiosis.

The last x-ray was taken on May 17, 2002, and again interpreted by Dr. Patel as positive for pneumoconiosis. However, Dr. Wheeler and Dr. Scott interpreted this x-ray as negative, and Dr. D'Angelo, whose qualifications are unknown, made no findings of pneumoconiosis. Given the negative interpretations by Dr. Wheeler and Dr. Scott, I find that this x-ray is negative for pneumoconiosis.

Given that these seven x-rays are all negative for pneumoconiosis, I find that the Claimant has not established the existence of pneumoconiosis under Section 718.202(a)(1).

There is no autopsy or biopsy evidence to consider, and thus the claimant has not

established the existence of pneumoconiosis under Section 718.202(a)(2).

Under Section 718.202(a)(3), a determination of the existence of pneumoconiosis may also be made by using the presumptions set out in 718.304, 305, or 306. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because it applies only to claims filed before January 1, 1982. Section 718.306 is only applicable in the case of a deceased miner. Since none of these presumptions is applicable, the existence of pneumoconiosis is not established under 718.202(a)(3).

Claimant can also establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See, Hoffman v. B&G Construction Co.,* 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.,* 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.,* 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP,*8 B.L.R. 1-139 (1985).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra.* Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder of fact to decide. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.,* 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.,* 9 B.L.R. 1-106 (1986).

In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probative weight to the most recent report. *Clark v. Karst-Robbins Coal Company,* 12 BLR 1-149 (1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. *Thorn v. Itmann Coal Company,* 3 F.3d 713 (4th Circuit 1993). Finally, a medical opinion may be given little weight if it is vague or equivocal. *Griffith v. Director, OWCP,* 49 F.3d 184 (6th Circuit 1995) and *Justice v. Island Creek Coal Company,* 11 BLR 1-91 (1988).

Here, the only physician who has provided an opinion that the Claimant has pneumoconiosis is Dr. Rasmussen. However, his conclusion is based on Dr. Patel's positive interpretation of the Claimant's x-rays, and the Claimant's history of exposure to coal mine dust. I have already found that the x-ray evidence is negative for the existence of pneumoconiosis. The only other basis for Dr. Rasmussen's opinion is the Claimant's history of coal mine dust exposure, which is not sufficient to support a finding of pneumoconiosis. I find that Dr. Rasmussen's opinion

on this issue is not well reasoned or supported by the objective medical evidence of record, and I accord it little weight.

Dr. Proctor, who treated the Claimant for a little over a year, stated that the Claimant's respiratory symptoms "almost certainly relate to his former coal mine employment." She relied on positive x-ray interpretations by Dr. Patel, as well as the Claimant's history of coal dust exposure. Since the Claimant had not smoked for 24 years, she concluded that his symptoms must be due to his history of coal dust exposure.

I find that Dr. Proctor's opinions are not well-reasoned, nor are they supported by the objective medical evidence of record, and thus they do not establish that the Claimant has pneumoconiosis. As discussed above, I have found that the x-ray evidence is negative for pneumoconiosis. Thus, Dr. Proctor's conclusions are based strictly on the Claimant's history of coal dust exposure. Moreover, her assumption that the Claimant's past cigarette smoking could have no effect on his pulmonary condition has been rebutted by Dr. Ghio and Dr. Branscomb. Finally, her statements are equivocal: she said, not that the Claimant had pneumoconiosis, but that his symptoms almost certainly related to his former coal mining employment.

The Claimant submitted the opinion of Dr. Zavelo, who recently saw the Claimant for exacerbation of his chronic pulmonary disease. Dr. Zavelo stated that the Claimant has "significant lung problems with airway obstruction," and that he has granulomatous changes on his x-ray. Beyond the fact that Dr. Zavelo did not state that the Claimant has pneumoconiosis, his identification of an airway obstruction "problem" is not supported, and indeed is contradicted by the objective evidence, in the form of the valid pulmonary function studies. Apparently, Dr. Zavelo relied on the results of spirometry testing on May 3, 2002; however, neither the report nor the tracings have been submitted. Considering that the Claimant's next most recent pulmonary function tests, on September 27, 2000, were rendered invalid by the Claimant's lack of cooperation, as well as the absence of the report and tracings, I find no basis to conclude that the results reported by Dr. Zavelo are reliable. In any event, without more, they do not support a conclusion that the Claimant has pneumoconiosis. I find that Dr. Zavelo's conclusions are poorly reasoned and unsupported by the objective medical evidence of record, and I accord them no weight.

In contrast, Dr. Fino, Dr. Castle, Dr. Repsher, Dr. Hayes, Dr. Ghio, Dr. Jarboe, Dr. Wiot, and Dr. Branscomb, each of whom reviewed the Claimant's medical records, concluded that the Claimant does not have pneumoconiosis, or any other type of pulmonary impairment. Their conclusions are based on the results of objective testing, clinical examinations that failed to show any symptoms consistent with pneumoconiosis, and negative x-ray results. All of these physicians acknowledged that the Claimant's history of coal dust exposure was sufficient to result in the development of pneumoconiosis, if he were a susceptible host. Giving the most weight to these opinions, which I find to be well-reasoned and supported by the objective medical evidence, I find that the overwhelming weight of this medical opinion evidence establishes that the Claimant does not have pneumoconiosis. Thus, the Claimant has not established by a preponderance of the

medical opinion evidence that he has pneumoconiosis.[6]

Viewing all of the newly submitted medical evidence as a whole, I find that it does not establish by a preponderance of the evidence that the Claimant has pneumoconiosis. Thus, the Claimant has not established a material change in conditions with respect to the issue of whether he has pneumoconiosis.

Total Disability Due to Pneumoconiosis

The Director also found that the Claimant had not established that he was totally disabled due to pneumoconiosis. Thus, if the Claimant establishes by a preponderance of the evidence that he is totally disabled due to pneumoconiosis, he has established a material change in conditions.

Unfortunately for the Claimant, the medical evidence of record overwhelmingly establishes that he is not disabled from a respiratory standpoint, from any cause. Thus, the results of the valid pulmonary function and arterial blood gas testing do not establish qualifying values under the regulations. Of the eleven physicians who examined the Claimant or reviewed his medical records, only two, Dr. Proctor and Dr. Zavelo, suggested that he had a totally disabling respiratory impairment. For the reasons discussed below, I accord their opinions little weight.

Thus, Dr. Proctor's opinion that the Claimant was unable to perform coal mine work or any job with similar dust exposure was based on the Claimant's history, as well as his bout with acute epiglottitis in November 1999. However, she acknowledged that arterial blood gas studies on August 30, 1999 were "reasonably normal," that the pulmonary function results obtained by Dr. Rasmussen on October 20, 1999 were normal, and that she herself did not obtain any objective test results that supported a finding of total respiratory disability. I find that Dr. Proctor's opinion, which rests on the Claimant's subjective history of symptoms, and his one-time serious throat infection from which he appears to have recovered without lasting effects, and which she maintains despite an abundance of objective evidence to the contrary, is not well-reasoned or reliable.

Dr. Zavelo, who examined the Claimant one time, stated that the Claimant suffers from significant lung problems with airway obstruction, and as a result should not work in the mines.

---

[6] The Claimant argues that Dr. Ghio perjured himself because he stated that he reviewed numerous x-rays that the Claimant had with him, when the Claimant did not provide any other x-rays for Dr. Ghio. I do not interpret Dr. Ghio's statement to imply that the Claimant physically handed the x-rays to Dr. Ghio; rather, I interpret it as referring to the file supplied by the Employer, which included other x-rays. Nor do I find that Dr. Hayes' inaccurate estimate of the number of years that he has been a B reader renders his opinions invalid. In any event, even if I were to completely discard Dr. Ghio's and Dr. Hayes' opinions, I would still conclude, based on both the lack of reliable evidence that the Claimant has pneumoconiosis, as well as the abundance of well-reasoned medical opinions that he does not, that the Claimant has not established that he has pneumoconiosis.

Beyond the fact that this is hardly an unequivocal statement of total respiratory disability, Dr. Zavelo based his opinion on pulmonary function testing performed on May 3, 2002, and in "August" 2002. But it is impossible to determine if these tests results are valid and reliable, as neither the report nor tracings are in the record. In contrast, the valid and reliable pulmonary function study results, as well as arterial blood gas study results, are normal. As Dr. Zavelo's opinion is not supported, and in fact is contradicted by the objective medical evidence of record, I find that it is entitled to little weight.

Relying on the well-reasoned and documented opinions of Dr. Fino, Dr. Castle, Dr. Repsher, Dr. Hayes, Dr. Ghio, Dr. Jarboe, Dr. Wiot, and Dr. Branscomb, all of whom rely on the objective and valid medical evidence of record, I conclude that the Claimant has not established, by a preponderance of the medical opinion evidence, that he is totally disabled from a respiratory impairment.[7]

The Claimant has not established a change in conditions since the September 1987 determination by the Director, and thus he is not entitled to consideration of his claim on the merits. I note, however, that even if he were, the evidence of record overwhelmingly establishes that he has not met the elements of entitlement, and is not entitled to benefits under the Act.

It should be pointed out that the Claimant's submissions to the Court indicate a misunderstanding on the Claimant's part about the effect of the April 15, 1982 determination by the West Virginia Occupational Pneumoconiosis Board. That determination is not binding on this Court, as the standards and criteria for entitlement to benefits used by the West Virginia Occupational Pneumoconiosis Board are different from the requirements under the Act. Nor is that determination persuasive in any way: the conclusion that the Claimant had pneumoconiosis was based on the interpretation of an April 14, 1982 x-ray, which is not in the record.[8]

In connection with the Claimant's previous claim, Dr. Diaz examined the Claimant for the Department of Labor on May 6, 1987. An x-ray of that date was interpreted as negative by Dr. Sargent and Dr. Wershba. Dr. Diaz's physical examination yielded normal results, as did the pulmonary function and arterial blood gas studies. Nevertheless, Dr. Diaz diagnosed simple

---

[7] The Claimant argues that Dr. Repsher's opinion is not reliable because he referred to pulmonary function tests performed on October 9, 2000, but the Claimant did not have any tests done on that date. Dr. Ghio performed pulmonary function testing on September 27, 2000; as the date of his report is October 9, 2000, it is obvious that Dr. Repsher mistakenly referred to the date of the report.

[8] The Claimant also relies on the determination by the Social Security Administration that he became disabled on August 30, 1999 (CX V). The Claimant submitted only the first page of the notice from SSA, and there is no indication of the nature of the disability found by SSA. In any event, the determination of disability by SSA is not binding, as the standards for entitlement under the Act are not the same as the Social Security disability standards.

pneumoconiosis, based solely on the Claimant's history of coal mine work.

The May 6, 1987 x-ray was subsequently read as positive by Dr. Patel. However, numerous other dually qualified physicians subsequently read this x-ray as negative. Thus, not only is the determination by the West Virginia Occupational Pneumoconiosis Board based on evidence not in the record, the overwhelming weight of the x-ray and medical opinion evidence since that time does not support a determination of pneumoconiosis.

Moreover, even if the Claimant had successfully established that he has pneumoconiosis, he would still be required to establish that he is totally disabled due to his pneumoconiosis. As discussed above, the overwhelming weight of the newly submitted medical evidence is to the contrary. The pulmonary function and arterial blood gas studies performed in connection with the Claimant's previous claim did not yield qualifying results, nor was there any medical opinion evidence that the Claimant was totally disabled by a respiratory condition. Nor does the April 15, 1982 determination by the West Virginia Occupational Pneumoconiosis Board support such a conclusion, as that award specifically states that no pulmonary function impairment attributable to pneumoconiosis was found. Indeed, the Claimant continued to work as a coal miner for some time after that.

In sum, even if all of the evidence of record is considered, the Claimant has not established by a preponderance of the evidence that he has pneumoconiosis. Even if he had, he has not established that he is totally disabled from a pulmonary standpoint, from any cause, much less from pneumoconiosis.

CONCLUSION

The Claimant has not established that he suffers from pneumoconiosis that arose out of his coal mine employment, or that he is totally disabled due to pneumoconiosis. The Claimant is therefore not entitled to benefits under the Act.

ORDER

It is ordered that the claim of Robert G. Hitt for benefits under the Black Lung Benefits Act is hereby DENIED.

A

LINDA S. CHAPMAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601,Washington, D.C. 20013-7601. *A copy of a Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.*